MARYLAND MEDICAID

EARLY & PERIODIC SCREENING, DIAGNOSIS & TREATMENT PROGRAM (EPSDT)

AUDIOLOGIST AND HEARING AID DISPENSER SERVICES

PROVIDER MANUAL

(Provider Type 19-Audiologist, Hearing Aid Dispenser)

[This manual is provided as a *tool* to assist in understanding Maryland Medicaid's EPSDT: Audiology Services and is to be used as a guide only. As a provider, it is your responsibility to adhere to established Program policies and regulations for these services. Refer to COMAR 10.09.51 for regulations that address EPSDT: Audiology Services and to COMAR 10.09.36 for regulations that address General Medical Assistance Provider Participation Criteria.]

July, 2010

MARYLAND MA EPSDT AUDIOLOGIST & HEARING AID DISPENSER SERVICES PROVIDER MANUAL
(Provider Type 19-Audiologist, Hearing Aid Dispenser)
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The information in this manual is intended for Maryland Medicaid participating and *enrolled* audiologists and hearing aid dispensers providing Early & Periodic Screening, Diagnosis & Treatment (EPSDT): Audiology Services. While the manual does not encompass everything about the Medicaid Program, the following information will be helpful in understanding coverage of EPSDT: Audiology Services. It is important that the regulations established for EPSDT: Audiology Services be reviewed by the participating audiologist and hearing aid dispenser. Refer to the following Division of State Documents website to review an online version of the current regulations. PLEASE NOTE: The Maryland Register and the Code of Maryland Regulations (COMAR) contain the only official text of regulations. The on-line version of the regulations is not the official text; it is a copy of the regulations as they appear on the COMAR On-Line website. If you need more COMAR information or wish to subscribe to the Maryland Register, contact the Division of State Documents.

www.dsd.state.md.us/comar COMAR 10.09.51

Overview

As a result of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Maryland Medicaid expanded its coverage of medically necessary services under its EPSDT Program to include those services provided by an audiologist. The screening provider (primary care provider, school, local health department etc.) will refer the EPSDT recipient to a hearing specialist for further evaluation and, if necessary, treatment (audiologist for hearing testing, otolaryngologist or otologist for medical evaluation).

Audiologist and hearing aid service coverage is limited to Maryland Medicaid's EPSDT Program population (20 years of age or younger) who are at risk for hearing impairment. At risk for hearing impairment means the condition of a recipient with a suspect or positive hearing screening or who possesses a risk factor listed on the High Risk Questionnaire as defined in COMAR 10.11.02.03.

As of November 1999, audiologist and hearing aid dispenser services for the EPSDT population (20 years of age or younger) were "carved out" from the managed care organization (MCO) payment system. These services were placed back into Maryland Medicaid's fee-for-service (FFS) system of payment. The recipient *does not* have to receive a preauthorization or referral from the MCO before visiting an audiologist for evaluation and/or treatment. The screening provider can proceed to directly refer those recipients with a positive or suspect hearing screening to a participating Maryland Medicaid audiologist for further evaluation and treatment without waiting for an MCO preauthorization or referral. It is expected that the audiologist will share the recipient's

Overview (continued)

care plan for audiologist services with the primary care provider. Maryland Medicaid requires preauthorization on certain services; it is important to review the EPSDT: Audiology Services Procedure Code and Fee schedule to determine if preauthorization for a service must be obtained from Medicaid *prior* to testing and treating the recipient. Additional information regarding preauthorization can be found in the regulations for this service and within these guidelines.

Please note: Hospital (unless independently enrolled in Medicaid from the hospital as an audiological center or group and assigned an EPSDT: Audiology Services provider number for billing purposes – i.e. billing on the CMS 1500 claim form), home health agency, inpatient facility, nursing home, RTC, local lead agency, school audiologist services and audiologist services in accordance with an IEP/IFSP, model waiver etc. are not addressed in this manual. Refer to the regulations that address that particular treatment setting. (Regulations for Maryland Medicaid services can be found at the above referenced COMAR website.)

Participating with Maryland Medicaid

In order to participate as a Maryland Medicaid audiologist or hearing aid dispenser provider, the provider shall:

Audiologist Services

- be licensed by the Maryland State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists to practice audiology, as defined in Health Occupations Article, Title 2, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction in which the audiology services are performed; or
- if providing services in a jurisdiction without licensure, shall meet the current standards set forth in the Code of Federal Regulations (42 CFR §440.110).

Hearing Aid Services

- be licensed by the Maryland State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists to dispense hearing aids and hearing aid accessories, as defined in Health Occupations Article, Title 2, Annotated Code of Maryland; or be licensed by the appropriate licensing body in the jurisdiction in which the hearing aids are dispensed.

Participating with Maryland Medicaid (continued)

Participation in Maryland Medicaid's EPSDT Audiology Services Program requires that the provider:

- Agrees to on-site visits by departmental staff, following a protocol established by the Department for the purpose of determining compliance with national or state standards for audiology and appropriate equipment necessary to perform required procedures;
- Meets the standards set forth in 29 CFR §1910.95, which is incorporated by reference; and
- Has the following available on site:
  - Sound field apparatus;
  - Visual reinforcement equipment;
  - Conditioned play audiometry; and
  - Speech audiometric materials specific to assessing the hearing status of infants, toddlers, children, and adolescents.

Coverage – General Information

Maryland Medicaid offers a wide range of coverable hearing and hearing aid services for its EPSDT (20 years of age or younger) population. Medically necessary hearing testing and treatment services provided by an audiologist to the EPSDT population are reimbursed through the fee for service (FFS) payment system. Following is Maryland Medicaid's definition for medically necessary (COMAR 10.09.51(.01) (21)):

"Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with currently accepted standards of good medical practice;

(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the consumer, family, or provider."

It is important to again note that an audiologist billing FFS Medicaid must be a participating and enrolled provider with the Maryland Medicaid Program. A Maryland Medicaid provider number is assigned to participating providers for billing and preauthorization purposes.

Coverage (continued)

Newborn hearing screens, services by a primary care provider, neurologist or other physician *to determine whether a child has a need for* occupational therapist, physical therapist, speech language pathologist or audiologist services continue to be coverable through the MCO payment system. Services that are developmental or pure tone audiologic screening tests provided by the primary care provider to identify children who need to be referred for further evaluation remain the responsibility of the MCO. Cochlear implant surgery is considered a medical procedure. This procedure is coverable under the MCO payment system as well.

From time to time, confusion arises as to whether to bill the MCO or FFS Medicaid for certain services rendered to an eligible Maryland Medicaid recipient. While this manual is specific to services provided by an audiologist and hearing aid dispenser, the following chart is provided for informational purposes to assist in determining payment coverage of hearing and certain other coverable Maryland Medicaid services. The age limitation for coverage is included on the chart. (Regardless if reimbursed through the MCO or FFS payment system, all coverable services ***must be medically necessary*** and the recipient's Medicaid eligibility must be valid on the date of service. [For general Medicaid knowledge, if a procedure/service/item is coverable through the FFS Maryland Medicaid system, the procedure/service/item is coverable through the MCO as well when payment is through the MCO payment system- keeping in mind that the procedure/ service /item itself may require preauthorization and must be medically necessary.]

Service	MCO	Fee for Service (FFS) Medicaid
Newborn Hearing Screens	regardless if inpatient, home birth or after discharge	----
Follow-up by an audiologist after failed newborn screening	-----	√
EPSDT Developmental or Pure Tone Audiologic Screening Tests	0-20	----
Primary Care Provider (PCP), Neurologist or Other Physician Services to Determine Whether a Child Has a Need for Occupational Therapy, Physical Therapy, Speech Language Pathology or Audiological Services	0-20	---
Hearing Evaluation and Treatment by an Audiologist	-----	0-20
Hearing Aids	-----	0-20
Sedation for ABR	0-99	----
Cochlear Implant Surgery	0-99	-----
Home Health Therapy	0-99	-----
Inpatient Therapy	0-99	-----
DME/DMS	0-99	-----

Coverage (continued)

Audiologists and hearing aid dispensers who participate in this Program must comply with criteria set forth in COMAR 10.09.36 General Medical Assistance Provider Participation Criteria 10.09.51 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Audiology Services and 10.09.23 Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Screening Services. Visit the following Division of State Documents website to view a copy of the referenced regulations:

www.dsd.state.md.us/comar (Title 10) (Subtitle 09)

Audiologist and hearing aid dispenser services are coverable for EPSDT recipients who are at risk for hearing impairment when the services are:

- necessary to correct or ameliorate defects and conditions discovered in the course of an EPSDT screen provided upon the referral of a screening provider. Hearing screen means the completed High Risk Questionnaire, an audiometric, pure tone air conduction test, or tympanometry performed by a physician or certified nurse practitioner (CNP) to identify the need for a referred hearing screening.
- rendered in accordance with accepted professional standards and when the condition of a participant requires the judgement, knowledge, and skills of a licensed audiologist or licensed hearing aid dispenser.

Covered Audiologist Services include but are not limited to:

- Audiological assessments.
- Electrophysiological measures such as auditory brainstem response (ABR), otoacoustic emissions, and brainstem auditory evoked response. Please note that at least one of the following criteria must be met for coverage of electrophysiological measures under the Maryland Medicaid Program:
    - Failure of the recipient to provide consistent behavioral responses to auditory signals, using procedures appropriate for the recipient's developmental age;
    - Presence of neuromotor involvement or behavioral disorder, or both, which precludes observation of consistent behavioral responses;
    - Failure to respond to test signal intensities appropriate for the recipient's developmental age, using developmentally appropriate test procedures;
    - Presence of inconsistencies in the results of tests administered during the audiological assessment which suggest, but do not define, a hearing impairment;
    - The Infant High Risk Questionnaire delineates a need; or
    - A physician refers the infant for the service.
- Hearing aid evaluations.

Coverage (continued)

Coverable hearing aid services include:

- Hearing aids which are:
    - Not used or rebuilt, and which meet the current standards set forth in 21 CFR §§801.420 and 801.421;
    - Recommended and fitted by an audiologist in conjunction with written medical clearance from a physician who has performed a medical examination on the recipient within 6 months prior to hearing aid recommendation;
    - Sold on a 30-day trial basis;
    - Fully covered by a repair warranty for a period of 2 years, at least 1 year of which is provided by the manufacturer at no cost to the Program, and
    - Insured for loss or theft for a period of 2 years per hearing aid.

- Hearing aid accessories and services, such as:

    - Replacement ear molds;
    - Replacement batteries;
    - Repairs after all warranties have expired;
    - Insurance policies for hearing aids purchased by the Medicaid Program as required by §B (1)(d) and (c) of this regulation; and
    - Extended repair warranties.

Please review the EPSDT: Audiology Services Procedure Code and Fee Schedule for additional coverable audiologist or hearing aid dispenser services. The schedule can be found at the following Program website:

www.dhmh.state.md.us/mma/providerinfo

Limitations

Coverable EPSDT services by an audiologist or hearing aid dispenser are limited to:

- Recipients who are under 21 years of age who are referred for the service or have had cochlear implant surgery;
- One audiological assessment per year, unless the time limitations are waived by the Program;
- One monaural or binaural hearing aid every 3 years unless the Program approves more frequent replacement; and
- Replacement of hearing aids that have been lost, stolen, or damaged beyond repair, after all warranties and insurance policies have expired.

Limitations (continued)

Coverable EPSDT services by an audiologist or hearing aid dispenser are limited to (continued):

- Repairs and replacements that take place after all warranties and insurance policies have expired
- A maximum of 48 batteries per recipient per year for a monaural hearing aid, or 96 batteries per recipient per year for a binaural hearing aid, purchased from the Department not more frequently than every 6 months, and in quantities of 24 or fewer for a monaural hearing aid, or 48 or fewer for a binaural hearing aid
- A maximum of 476 disposable batteries for a cochlear implant per calendar year, purchased every 6 months in quantities of 238 or fewer
- Two replacement cochlear implant component rechargeable batteries per 12-month period
- Two cochlear implant replacement transmitter cables per 12-month period
- Two cochlear implant replacement headset cables per 12-month period; and
- Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid
- manufacturer processing fee for replacement of lost hearing aid(s) when not covered by warranty

Services, which are not covered, include:

- Services not medically necessary;
- Hearing aids and accessories not medically necessary;
- Cochlear implant services and external components not medically necessary;
- Cochlear implant audiological services and external components provided less than 90 days after the surgery or covered through initial reimbursement for the implant and the surgery;
- Spare or backup cochlear implant speech processors;
- Upgrades to new generation hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;
- Replacement of hearing aids, equipment, cochlear implant speech processors, and other components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;
- Spare or backup hearing aids, equipment, or supplies;
- Repairs to spare or backup hearing aids, equipment, or supplies;
- Investigational, experimental, or ineffective services or devices, or both;
- Educationally or socially needed services or equipment;
- Testing for educational or behavioral planning (recipient should contact the local school system);
- Replacement of improperly fitted earmold or earmolds unless:
    - Replacement service is administered by someone other than the original provider; and replacement service has not been claimed before;
- Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and
- Loaner hearing aids.
- manufacturer processing fee for replacement of lost spare aid(s)

Eligibility Verification System – (EVS)

The Eligibility Verification System (EVS) is a telephone inquiry system that enables health care providers to verify quickly and efficiently a Medicaid recipient's current eligibility status. Medicaid eligibility should be verified on EACH DATE OF SERVICE *prior* to rendering services. Although Medicaid eligibility validation via the Program's EVS system is not required, it is to your advantage to do so to prevent the rejection of claims for services rendered to a canceled/non-eligible recipient. ***Before* rendering a Medicaid service, verify the recipient's eligibility *on the date of service* via the Program's Eligibility Verification System (EVS) 1-866-710-1447.**

If you need additional EVS information, please call the Provider Relations Unit at 410-767-5503 or 800-445-1159. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at www.emdhealthchoice.org. The provider must be enrolled in eMedicaid in order to access the web EVS system. For additional information view the website or contact 410-767-5340 for provider application support.

Preauthorization

The EPSDT: Audiology Services Procedure Code and Fee Schedule lists the services that require Maryland Medicaid preauthorization. This schedule is specific to audiologists and hearing aid dispensers. Services by an audiologist or hearing aid dispenser that require preauthorization include:

- Auditory brainstem response (ABR) for recipients who are 3 years old or older
- Evaluation of central auditory function
- Certain hearing aids
- Unlisted hearing services
- Services that exceed Program limitations

A preauthorization request for EPSDT audiologist or hearing aid dispenser services is submitted on form DHMH 4525. The provider must complete, sign (original signature from the audiologist or hearing aid dispenser is required; a facsimile is not acceptable) and mail to the address listed on the form *prior* to rendering the service to the recipient to ensure coverage. It is imperative that correct procedure codes be placed on the request form. Incorrect or omitted information will result in a rejected request. It is important to note that the coding on the preauthorization correlates with the claim. Incorrect procedure codes, units of service, or authorized dates of service ultimately affects claims processing and reimbursement.

Preauthorization (continued)

Medical necessity must be demonstrated for all Maryland Medicaid services and/or items (including those that do not require preauthorization). Each preauthorization request should include a copy of the following documentation:

Hearing Aid

- written medical clearance from the physician who has performed the medical examination on the recipient within the last 6 months of the hearing aid recommendation
- audiogram
- audiologist report
- when necessary, additional documentation to substantiate the medical necessity for the service and/or item

Hearing tests requiring preauthorization. and services that have exceeded MA limitations should include documentation such as the following:

- audiologist report
- audiogram
- previous test results
- physician Rx for the test
- supplemental documentation to further substantiate medical necessity

Unlisted cochlear implant supplies, equipment, repair or replacement of speech processor (external components only) should include the following:

- for new cases submitted to Medicaid, cochlear implant history including type and date of implant must be included with preauthorization request
- audiologist report substantiating medical necessity for service
- as appropriate:
  - certification that the existing equipment no longer appropriately corrects or ameliorates the medical problem/condition
  - certification that requested equipment is no longer functional and not repairable;
  - certification that all equipment warranties have expired

Preauthorization for EPSDT Audiology Services will be issued by the Department when the provider:

- meets Program procedures and limitations; and
- submits to the Department adequate documentation substantiating that the services to be preauthorized are medically necessary

Preauthorization (continued)

Determination of authorization is issued via a letter after the receipt and review of the request (form DMHM-4525) has taken place. A copy of the notification letter is sent to the provider as well as to the recipient. Preauthorization for audiology services expires 6 months from the authorized span of time that is issued by the Department and is valid if the recipient is eligible at the time the service is rendered to the recipient. The recipient's parent or guardian may appeal a denial of coverage *within* 30 days of notice. He/she may do so pursuant to COMAR 10.01.04 –Fair Hearing Appeals by writing to:

Executive Director; Office of Health Services
Attn: Appeals
201 W Preston St lst FL
Baltimore MD 21201- 2323.

Note: Preauthorization does not guarantee payment. The recipient must be Medical Assistance eligible on the date of service. Please check the recipient's eligibility prior to rendering service. [Verify the recipient's Maryland Medicaid eligibility via the Program's Eligibility Verification System (EVS) 1-800-492-2134 or 410-333-3020.]

Billing Information

[Please note: Services such as developmental screens or pure tone audiologic screening tests provided by a physician or nurse practitioner to identify children who need a referral for further evaluation are not billable to the Medical Assistance Program. These screening tests remain the responsibility of the child's MCO and need to be provided within the MCO'S guidelines. Newborn hearing screens, in or out of the hospital, also remain under the MCO payment system. In addition, payment for durable medical equipment, other than hearing aids and related items, remain under the MCO payment system.]

It is inappropriate for an audiologist or hearing aid dispenser to bill the Program by using a physician's provider number. Because the Program does not recognize audiologists as physician extenders, they must independently enroll with the Program and be assigned their own provider number. The assigned audiologist provider number must be used on all claims and preauthorization requests. If a group practice of audiologists, a *group provider number* must also be assigned and used on claims and preauthorization requests along with the *rendering audiologist* provider number. Contact the Program's Provider Enrollment Office at 410-767-5340 for provider enrollment application(s).

It is the provider's responsibility to *bill* the Program the actual acquisition cost for

Billing Information (continued)

hearing aids, accessories and supplies. An authorized maximum amount for a preauthorization by the Program does not give the provider the right to bill above and beyond the acquisition cost for the service. A copy of the manufacturer's invoice listing the actual cost for the item must be maintained in the recipient's file and be made available upon request by the Program or its designee.

Effective 03/01/08, a manufacturer processing fee for replacement of lost aid(s) is coverable when documentation substantiating the loss and cost is attached to the claim. For review and pricing purposes, a copy of the completed and signed loss report submitted to the manufacturer as well as the manufacturer's invoice listing the charge for the service must be attached to the claim. When billing for this service, procedure code V5299 must be used with modifier RP. [The procedure code alone without the modifier requires preauthorization. As a result, a claim listing the code without the RP modifier will be rejected for processing.] If the manufacturer voids loss/damage coverage for the replacement aid(s), bill the supplemental insurance (Esco, etc.) covering loss/damage for the replacement aid(s) on the same claim.

Note: Services that require preauthorization must be billed on a separate claim form with the preauthorization number posted in box 23.

Following is information regarding billing the Maryland Medicaid recipient for services rendered:

- The provider *can* bill a Maryland Medicaid recipient under the following circumstances:
  - if the service provided is not covered by Medical Assistance and notification has been given to the recipient *prior* to providing the service; or
  - if the recipient is not eligible for Medical Assistance on the date you provide the service(s).

- A Medical Assistance recipient *cannot* be billed under the following circumstances:
  - for a covered service when Medical Assistance is billed;
  - when Medical Assistance is billed for a covered service and Medical Assistance denies the claim because of billing errors, such as:

    - ❖ incorrect procedure codes,
    - ❖ lack of preauthorization,
    - ❖ invalid consent forms,
    - ❖ unattached necessary documentation,
    - ❖ incorrectly completed form,
    - ❖ filing after the time limitations, or other provider errors

Billing Information (continued)

- when Medical Assistance denies a claim because Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
- for the difference in charges and the amount Medical Assistance has paid;
- for transferring the recipient's medical records to another health care provider;
- when services were determined to not be medically necessary.

Payment Procedures

Providers shall submit requests for payment for Audiology services as stated in COMAR 10.09.36. A copy of the EPSDT: Audiology Services Procedure Code and Fee Schedule can be viewed by visiting the following Program website:

www.dhmh.state.md.us/mma/providerinfo

Following are billing and payment criteria for participating audiologist/hearing aid service providers:

- The Provider must charge the Program the usual and customary charges, not exceeding those charged to the general public for similar professional services.
- The provider must charge the actual acquisition cost for hearing aids, supplies and equipment.
- The actual date of service must be used for all procedure codes including hearing aids and equipment.
- The provider must submit the request for payment on the form designated by the Department.

The provider may not bill the Department for:

- Completion of forms and reports;
- Broken or missed appointments;
- Professional services rendered by mail or telephone; and
- Services that are provided at no charge to the general public.

The Provider shall:

- refund payment back to the Program for aids or supplies, or both that have been returned to the manufacturer.
- give the Program the full advantage of any and all manufacturer's warranty and trade-ins offered on the aids or equipment or both.
- accept payment from Medical Assistance as payment in full for a covered service.

Payment Procedures (continued)

Audiological centers licensed as a part of a hospital may charge for and be reimbursed according to rates approved by the Health Services Cost Review Commission (HSCRC), set forth in COMAR 10.37.03. A hospital claim form(UB92) is submitted to the Program using the hospital provider number. [In this instance, because these services are included in the HSCRC rates, the center could not be enrolled independent of the hospital under the EPSDT: Audiology Services program and would not be assigned an EPSDT: Audiology Services provider number (provider type 19) for billing purposes i.e. cannot bill on both the UB92 and CMS1500.]

The Program shall:

- reimburse for covered services at the lower of the Provider's usual and customary charge to the general public; or the Program's fee schedule, whichever is less.
- reimburse the Provider the actual acquisition cost for the following services: hearing aids, accessories and supplies and external cochlear implant accessories and supplies.
- not make a direct payment to recipients.
- not reimburse the claims received by the Program for payment more than 9 months after the date of service.

The Program reserves the right to return to the provider, before payment, all invoices not properly signed or completed as required by the Department.

The Program is not responsible for any reimbursement to a provider for any service provided which requires preauthorization unless the Program has granted preauthorization.

For additional billing information, refer to the Program's manual for billing on the CMS1500. The manual can be found at the following website:

www.dhmh.state.md.us/mma/providerinfo

Records must be maintained on all services provided to each Medical Assistance patient and be available to the Medical Assistance Program upon request. Records must be maintained for a 6-year period.

Remittance Advice (RA)

As of the December 1, 2007 payment date, a paper remittance advice (RA) will no longer be mailed via the mail system. Instead an electronic copy of the weekly RA will be available on Monday mornings via the Program's Web Services portal – eMedicaid. After enrolling in eMedicaid, the Administrator will be able to access to this link. Sign up for eMedicaid at the following website: www.emdhealthchoice.org Complete a Remittance Advice Preferences form if you do not have access to the internet. Return the form to the address or fax number listed on the form. Contact the Provider Enrollment office at 410-767-5340 if you have questions about the form or if a form was not included with these guidelines.

The Health Insurance Portability and Accountability Act Of 1996(HIPAA)

HIPAA is the Health Insurance Portability and Accountability Act, a Federal law enacted on August 21, 1996. HIPPA's purpose is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of administrative and financial data, provide security requirements for transmitted information, and to protect the privacy of identifiable health information.

For more information on HIPPA, review the following informative web sites:

www.dhmh.state.md.us/hipaa **www.wedi.org**

NPI - National Provider Identifier

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for health care providers. HIPAA covered entities such as health care providers who conduct HIPAA standard transactions, health care clearinghouses, and all but small health plans, must use only the NPI. HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the NPI to identify covered healthcare providers in standard transactions.

Refer to the following Department of Health and Mental Hygiene website for important information regarding the NPI:

www.dhmh.state.md.us/html/hotissues_npi.htm

Other Insurance

If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for the services in these guidelines, the provider should seek payment from that source first. If an insurance carrier rejects the claim **or pays less than the amount allowed by the Medicaid Program**, the provider should submit a claim to the Program. A copy of the insurance carrier's notice or remittance advice should be kept on file and available upon request by the Program. In this instance, the CMS-1500 must reflect the letter K [services not covered] in box 11 of the claim form.

Overpayment

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of an overpayment is illegal.

Fraud And Abuse

It is illegal to submit reimbursement requests for:

- amounts greater than the usual and customary charge for the service. If there is more than one charge for a service, the amount billed to the Maryland Medical Assistance program should be the lowest amount billed to any person, insurer, health alliance or other payor;
- amounts greater than the acquisition cost for hearing aids, supplies and equipment;
- services, which are either not provided, or not provided in the manner, described on the request for reimbursement. In other words, you must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service;
- multiple, individually described or coded procedures if there is a comprehensive procedure which could be used to describe the group of service provided;
- any procedures other than the ones you actually provided;
- unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service;
- items or services which are performed without the required referrals or preauthorizations; or
- services for which you have received full payment by another insurer or party.

MOST FREQUENTLY REQUESTED TELEPHONE NUMBERS

Children's Health Program (CHPs)	(800) 456-8900
Eligibility Verification System (EVS)	1-866-710-1447
General Provider Relations	
Claims Resolution (Billing Questions, Payment Issues)	(410) 767-5503 or (800) 445-1159
Tape Billing - technical problems	(410) 767-5977
Third-Party Liability (other insurance)	(410) 767-1765
Missing Payment Voucher/Lost or Stolen Check	(410) 767-5344
Recoveries	(410) 767-1783
Medicaid Liaison Unit	(410) 767-5445
Healthchoice (Managed Care Organizations)	
Key Facts, Benefits and Services	(410) 767-1482
Enrollment Broker	(800) 977-7388
Provider Hotline	(800) 766-8692
Recipient Hotline	(800) 284-4510
Public Mental Health System	1-800-565-9688
Case Management [REM]	1-800-565-8190
Medicaid Policy/Coverage Issues	
Audiology Services	(410) 767-1722
School Based Health Centers	(410) 767-5706
IEP/IFSP Services	(410) 767-1903
Dental Services	(410) 767-5706
DME/DMS	(410) 767-1476
Preauthorization-disposables	(410) 767-1739
Preauthorization-durable medical	(410) 767-1739
Preauthorization: Audiology and Vision	(410) 767-1722
Preauthorization-Private Duty Nursing	(410) 767-1712
Healthy Kids/EPSDT Program	(410) 767-1683
Healthy Start/Family Planning	(410) 767-6750
Laboratory	(410) 767-5706
Model Waiver	(410) 767-5220
Physicians/Nurse Practitioners	(410) 767-1722
Autism Waiver	(410) 767-5220
Pregnant Women And Children's Information Hotline	(800) 456-8900
Provider Master File (Enrollment) (Application, Address Changes)	(410) 767-5340
Board of Audiologists/Hearing Aid Dispensers/Speech Language Pathologists	(410) 764-4725

UPDATE MARYLAND MEDICAID
REMITTANCE ADVICE (RA) PREFERENCES

Date: _____

Notify the Program: If you do not have internet access and want to continue to receive the paper RA, please complete the form and fax or mail it to:

Maryland M.A. Program
Provider Enrollment
201 W. Preston Street, Room LL-3
Baltimore, MD 21201

FAX# 410-333-5341

☐ **I want to continue receiving the weekly paper remittance advice(s).**

Provider Number (Include all Locations):

_____

_____

_____

Provider Name: _____

Address: _____

_____

Office Representative Name: _____

Contact Phone Number: _____

Please provide a contact name and phone number that the Program may call, if we have any questions concerning this information. **Update through eMedicaid:** Sign on to eMedicaid as the Administrator of your organization. The website is: www.emdhealthchoice.org. Once signed in, the Administrator can access the **Update Remittance Advice Preference** link. To continue receiving a paper RA, check "Yes". You may opt-in or opt-out at any time.

If you have any questions, please contact Provider Enrollment at 410-767-5340.